

PRIVATE AND CONFIDENTIAL

CONFIDENTIAL
HEALTH
QUESTIONNAIRE

PERSONAL DETAILS

(Please print)

Mr/Mrs/Ms/Miss: -----
Surname Given names (in full)

Preferred Name (Nickname): ----- Male [] Female []

Date of Birth: ----- Age: ----- Marital Status: -----

Address: ----- Postcode:-----

Telephone No's: Home: ----- Work: ----- Mobile: -----

E-mail Address: -----

Occupation: ----- Business Name:-----

Partner's Name: ----- Number of children: -----

Name of Emergency Contact: ----- Telephone No: -----

How did you find out about us? Tel [] Sign [] Dr [] Patient/Family/Friend [] Name:-----

CURRENT HEALTH HISTORY

Purpose of this appointment? -----

Caused by? ----- When did this start? -----

Have you had it before? Yes [] No [] Have you had any time off work? Yes [] No []

Will you be making an insurance claim? eg. Workers Compensation or Motor Accident Yes [] No []

Do you have private health insurance? Yes [] No [] Who is your insurer? -----

Any other health complaints? -----

Who is your normal medical doctor? -----

What medications are you now taking? -----

PAST HEALTH HISTORY

Previous hospitalisations or operations:

Reason(s):----- Date(s):-----

Major falls or accidents:

Injuries:----- Date(s):-----

Previous x-rays? Yes [] No [] Area(s): -----

Date(s): -----

Previous Chiropractor: ----- Date of last visit: -----

Please tick if you have or have had any of the following:

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Unexplained Weight Loss |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin conditions | <input type="checkbox"/> High/Low Blood Pressure |

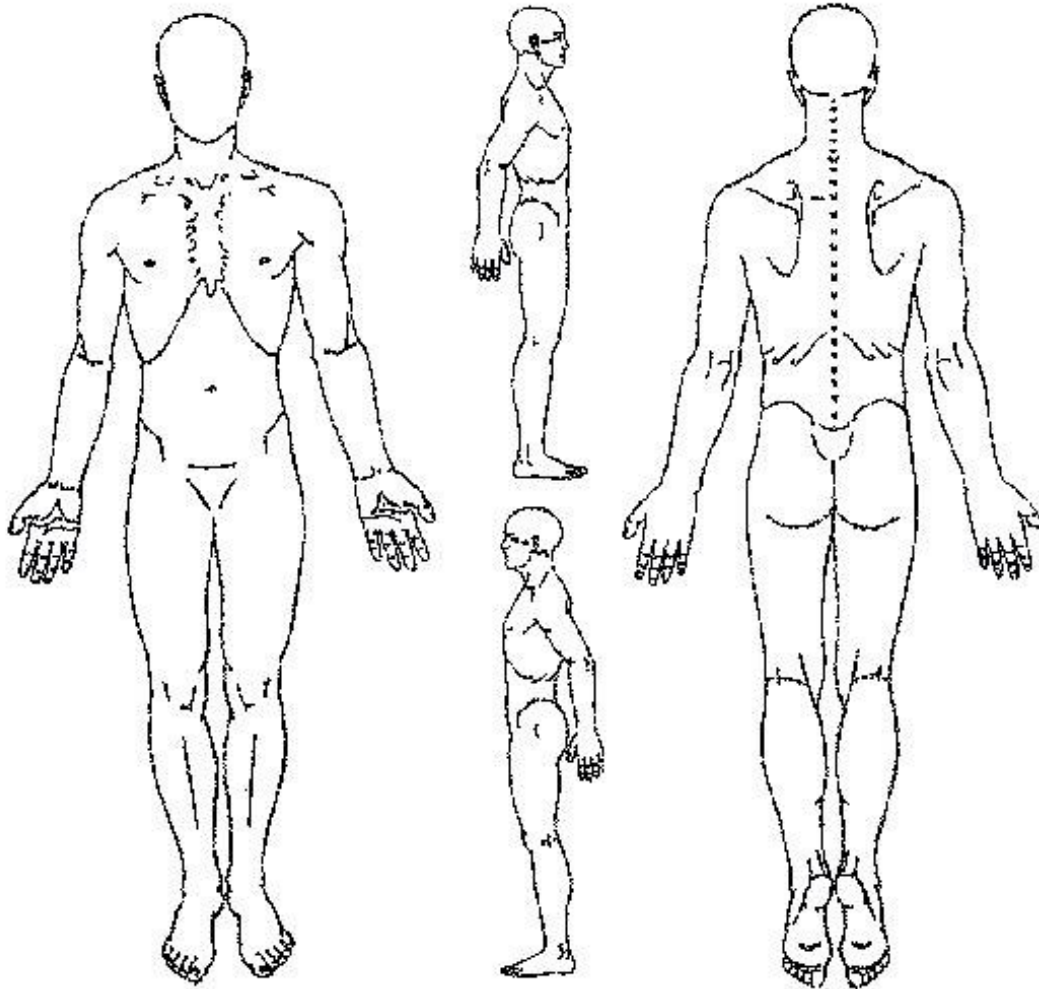
Please Turn Over

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SYMPTOM DIAGRAM

Please mark the areas on your body where you feel the described sensation(s). Use the appropriate symbol(s) to mark areas of radiating pain. Include all affected areas. You may draw in the face as well.

- Burning xxxxxxxx Numbness oooooooooo Pins and needles ^^^^^^^^^^
- xxxxxxxx oooooooooo ^^^^^^^^^^
- Aching ===== Stabbing /////////////// Other >>>>>>>
- ===== /////////////// >>>>>>>



PAIN SCALE

Please rate the severity of your pain at the moment by crossing one box on the following scale:

0	1	2	3	4	5	6	7	8	9	10
No pain					Extreme Pain					

DECLARATION

I hereby declare that: i.) the information supplied is correct to the best of my knowledge; and
ii.) if an insurance claim is denied, then I am responsible for all fees.

Patient Signature:----- Date:-----

Parent/ Guardian Signature:----- Date:-----